ACA Enrollment Worksheet

Client Demographic Data	
(information provided should match the enrollment application)	

Client Name:		Date of Birth:	
Complete Address:			
Social Security Number:		Primary Phone Number:	

Client Enrollment Data			
Check One:	☐ New Enrollment	☐ Re-enrollment	☐ Corrected/Updated Enrollment Information
Did the client enroll in a family plan? ☐ Yes ☐ No			
If yes, provide name of subscriber/main policy holder:			
**List the names of family members on the family plan & their dates of birth.			

Name:		Date of Birth:	
Name:		Date of Birth:	

Name of Insurance Carrier:		Plan Effective Date:	
Name of Insurance Plan Enrolled In:			

Monthly Premium Before Tax Credit Applied:		Tax Credit Amount:		Monthly Premium After Tax Credit Applied:	
Maximum Out of Pocket (MOOP):		Insurance Member ID or Billing ID, if available:			

Premium Effective Date *(if different from the Plan Effective Date):*

Enrollment Assister Name:		Agency/Company:	
Date Enrollment Completed:		Phone Number:	
Comments:			

This Section for Payment Processor Use Only	
(VDH staff or designated subrecipients)	

Payment Date:		Payment Amount:	
Payment Method:		Auth#/Check #/Etc:	
Date Keyed in VDH Database:		Keyed By:	
Comments:			

This Section for VDH Staff Use Only					
Initial Rvw/Cmplt:		Date:		Data Entry:		Date:	
Addtl Pmt Req – Amt:		Date Due:		Mths Addtl Pmt Cov:	
Name of Insurance Carrier:		Insurance Member ID:	
Plan End Date:		Verif Mthd:	☐Client/client bill	☐C.M./Provider	☐Carrier
Comments:					

**All persons on the plan must be enrolled in the VDH medication access program. If not enrolled in the program, these individuals will need to enroll in a separate insurance plan.

Mail or fax completed worksheet with all other appropriate documents to:
Virginia Department of Health, 109 Governor Street 1st floor, Richmond, VA 23219
Phone: 1-855-362-0658; Fax: 804-864-8050; Toll Free Fax: 877-837-2853